the ranking member of the subcommittee; Chairman PALLONE and Chairman DINGELL and Ranking Member BARTON.

Madam Speaker, as has been described by my colleagues, in 1998 the CLIA, or the Clinical Laboratory Improvement Amendments, went into effect. The law was passed. And it took them 4 years for the provision to evaluate the performance of laboratories interpreting Pap tests or Pap smears to be put into law or to have the rule finalized by Health and Human Services. The problem is that program then sat on the shelf for 13 years. So in 2005 the rules were then put into effect and enforced. And therein lies the program.

This program currently in place is based upon more than a decade old, even 15, 16 years old, 1992, regulatory approach that doesn't reflect the modern science and real-world laboratory practice. It does little to help patients or physicians charged with caring for them. The approach of relying on government-driven individual proficiency testing to evaluate the quality of Pap smear interpretations is both outdated and not cost effective.

So the solution is within the bill that we have before us today, H.R. 1237. There's a companion bill, Madam Speaker, over in the Senate, S. 2510, and I'm hopeful, as Congressman DEAL said, that we will be able to get this legislation through both Chambers during this session.

The Cytology Proficiency Improvement Act modifies CLIA by suspending the current regulation that subjects pathologists and others who screen for cervical cancer to annual proficiency testing and instead requires annual continuing medical education that would provide laboratory professionals opportunities to improve their screening and interpretation skills in a nonpunitive environment. The bill allows for an orderly phase-out of the current program and establishes reasonable timelines for the implementation of the new program. The educational approach is consistent with that included in the Mammography Quality Standards Act, a program that is remarkably effective. So the bill would ensure continuing education keeps up with the technology in the field and that clinicians are using day after day after day to help save lives of Americans all across our Nation. This is a major move in the right direction.

I want to thank once again all of those involved and encourage my colleagues to support the bill.

Mrs. CAPPS. Madam Speaker, I continue to reserve the balance of my time.

Mr. DEAL of Georgia. Madam Speaker, I urge the adoption of the bill.

Madam Speaker, I yield back the balance of my time.

Mrs. CAPPS. Madam Speaker, I have no further requests for time and again would like to commend my colleagues Representative GORDON and Representative DEAL and also the Women's Caucus for their much hard work and commitment on this important piece of legislation.

This bill would improve the quality of women's health care, and I strongly encourage all of our colleagues to join in support of H.R. 1237.

Mrs. MYRICK. Madam Speaker, I rise today in support of H.R. 1237, the Cytology Proficiency Improvement Act. I am pleased to see that the House will vote today on revamping a 16-year-old CMS regulation—from 1992—that calls for a Federal program to test the proficiency of individual laboratory professionals who read Pap tests.

I first became aware of the need to revisit this outdated regulation several years ago, in 2005, when CMS first began implementation of the program long after it was first put on the books. Congress knows well that promulgating regulations and implementation can do more harm than good.

The current oversight model that CMS is using is intended to help ensure that Pap tests are being read accurately—to improve public health. However, the approach established more than a decade ago, and being used today, doesn't necessarily protect women, improve quality or further our fight against cervical cancer.

H.R. 1237 provides an alternative. It redirects the current ''testing'' scheme to require pathologists and other lab technicians who read Pap tests to participate in an annual continuing medical education, CME program where their skills would be assessed and where the latest advances in Pap test practice could be shared. It would complement extensive Pap test quality controls that labs must already meet under the Clinical Laboratory Improvement Act. The Mammography Quality Standards Act includes a similar CME approach.

I've talked to pathologists in my district to better understand what it would take to add value to their profession, rather than just more red tape. Dr. Jared Schwartz was one of those who educated me and lent his expertise. He is now serving as president of the College of American Pathologists and is a strong advocate for ensuring access to Pap tests for all women. The laboratory and medical community support this bill, and I'm pleased to support it.

Mr. BUCHANAN. Madam Speaker, I rise today in support of H.R. 1237, the Cytology Proficiency Improvement Act of 2007. I am a cosponsor of this important legislation, which enhances women's health by establishing a continuing medical education requirement for pathologists and laboratory professionals who examine Pap tests to screen for cervical cancer.

I recently toured Sarasota Pathology and heard directly from my constituents about the importance of this bill and its potential to help save lives.

This legislation amends the Clinical Laboratory Improvements Amendments of 1988, CLIA, which mandated a cytology proficiency test to be administered by the Federal Government. However, the program lay inactive until 2005, which, because of scientific advancements makes the test obsolete and out of date.

Unlike the current CLIA testing model, H.R. 1237, with its annual continuing medical education requirement, will provide the means to increase the skills necessary to identify potential cervical cancer, and will keep pace with new science.

H.R. 1237 is modeled after the Mammography Quality Standards Act, MQSA, which was passed in 1992. That bill ensured women would have access to quality mammography procedures. This bill requires similar educational testing for pathologists.

The American Medical Association, the College of OBGYNs, the College of American Pathologists, the American Society for Clinical Pathology, the College of Nurse Midwifes, and the Cancer Research and Prevention Foundation endorse the bill.

Finally, I want to mention that the Congressional Budget Office has determined that it will not cost the Federal Government any additional expenditure.

Madam Speaker, I urge my colleagues to join with me in support of a bill that will greatly improve the quality of women's health care in America.

Mrs. CAPPS. Madam Speaker, I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentlewoman from California (Mrs. CAPPS) that the House suspend the rules and pass the bill, H.R. 1237, as amended.

The question was taken; and (two-thirds being in the affirmative) the rules were suspended and the bill, as amended, was passed.

A motion to reconsider was laid on the table.

SAFETY OF SENIORS ACT OF 2007

Mrs. CAPPS. Madam Speaker, I move to suspend the rules and pass the Senate bill (S. 845) to direct the Secretary of Health and Human Services to expand and intensify programs with respect to research and related activities concerning elder falls.

The Clerk read the title of the Senate bill.

The text of the Senate bill is as follows:

S. 845

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Safety of Seniors Act of 2007''.

SEC. 2. AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT.

Part J of title III of the Public Health Service Act (42 U.S.C. 280b et seq.) is amended—

(1) by redesignating section 393B (as added by section 1401 of Public Law 106–386) as section 393C and transferring such section so that it appears after section 393B (as added by section 1301 of Public Law 106–310); and

(2) by inserting after section 393C (as redesignated by paragraph (1)) the following:

''SEC. 393D. PREVENTION OF FALLS AMONG OLDER ADULTS.

''(a) PUBLIC EDUCATION.—The Secretary may—

''(1) oversee and support a national education campaign to be carried out by a nonprofit organization with experience in designing and implementing national injury prevention programs, that is directed principally to older adults, their families, and

health care providers, and that focuses on reducing falls among older adults and preventing repeat falls; and

''(2) award grants, contracts, or cooperative agreements to qualified organizations, institutions, or consortia of qualified organizations and institutions, specializing, or demonstrating expertise, in falls or fall prevention, for the purpose of organizing State-level coalitions of appropriate State and local agencies, safety, health, senior citizen, and other organizations to design and carry out local education campaigns, focusing on reducing falls among older adults and preventing repeat falls.

''(b) RESEARCH.—

''(1) IN GENERAL.—The Secretary may—

''(A) conduct and support research to—

''(i) improve the identification of older adults who have a high risk of falling;

''(ii) improve data collection and analysis to identify fall risk and protective factors;

''(iii) design, implement, and evaluate the most effective fall prevention interventions;

''(iv) improve strategies that are proven to be effective in reducing falls by tailoring these strategies to specific populations of older adults;

''(v) conduct research in order to maximize the dissemination of proven, effective fall prevention interventions;

''(vi) intensify proven interventions to prevent falls among older adults;

''(vii) improve the diagnosis, treatment, and rehabilitation of elderly fall victims and older adults at high risk for falls; and

''(viii) assess the risk of falls occurring in various settings;

''(B) conduct research concerning barriers to the adoption of proven interventions with respect to the prevention of falls among older adults;

''(C) conduct research to develop, implement, and evaluate the most effective approaches to reducing falls among high-risk older adults living in communities and long-term care and assisted living facilities; and

''(D) evaluate the effectiveness of community programs designed to prevent falls among older adults.

''(2) EDUCATIONAL SUPPORT.—The Secretary, either directly or through awarding grants, contracts, or cooperative agreements to qualified organizations, institutions, or consortia of qualified organizations and institutions, specializing, or demonstrating expertise, in falls or fall prevention, may provide professional education for physicians and allied health professionals, and aging service providers in fall prevention, evaluation, and management.

''(c) DEMONSTRATION PROJECTS.—The Secretary may carry out the following:

''(1) Oversee and support demonstration and research projects to be carried out by qualified organizations, institutions, or consortia of qualified organizations and institutions, specializing, or demonstrating expertise, in falls or fall prevention, in the following areas:

''(A) A multistate demonstration project assessing the utility of targeted fall risk screening and referral programs.

''(B) Programs designed for community-dwelling older adults that utilize multicomponent fall intervention approaches, including physical activity, medication assessment and reduction when possible, vision enhancement, and home modification strategies.

''(C) Programs that are targeted to new fall victims who are at a high risk for second falls and which are designed to maximize independence and quality of life for older adults, particularly those older adults with functional limitations.

''(D) Private sector and public-private partnerships to develop technologies to prevent falls among older adults and prevent or reduce injuries if falls occur.

''(2)(A) Award grants, contracts, or cooperative agreements to qualified organizations, institutions, or consortia of qualified organizations and institutions, specializing, or demonstrating expertise, in falls or fall prevention, to design, implement, and evaluate fall prevention programs using proven intervention strategies in residential and institutional settings.

''(B) Award 1 or more grants, contracts, or cooperative agreements to 1 or more qualified organizations, institutions, or consortia of qualified organizations and institutions, specializing, or demonstrating expertise, in falls or fall prevention, in order to carry out a multistate demonstration project to implement and evaluate fall prevention programs using proven intervention strategies designed for single and multifamily residential settings with high concentrations of older adults, including—

''(i) identifying high-risk populations;

''(ii) evaluating residential facilities;

''(iii) conducting screening to identify high-risk individuals;

''(iv) providing fall assessment and risk reduction interventions and counseling;

''(v) coordinating services with health care and social service providers; and

''(vi) coordinating post-fall treatment and rehabilitation.

''(3) Award 1 or more grants, contracts, or cooperative agreements to qualified organizations, institutions, or consortia of qualified organizations and institutions, specializing, or demonstrating expertise, in falls or fall prevention, to conduct evaluations of the effectiveness of the demonstration projects described in this subsection.

''(d) PRIORITY.—In awarding grants, contracts, or cooperative agreements under this section, the Secretary may give priority to entities that explore the use of cost-sharing with respect to activities funded under the grant, contract, or agreement to ensure the institutional commitment of the recipients of such assistance to the projects funded under the grant, contract, or agreement. Such non-Federal cost sharing contributions may be provided directly or through donations from public or private entities and may be in cash or in-kind, fairly evaluated, including plant, equipment, or services.

''(e) STUDY OF EFFECTS OF FALLS ON HEALTH CARE COSTS.—

''(1) IN GENERAL.—The Secretary may conduct a review of the effects of falls on health care costs, the potential for reducing falls, and the most effective strategies for reducing health care costs associated with falls.

''(2) REPORT.—If the Secretary conducts the review under paragraph (1), the Secretary shall, not later than 36 months after the date of enactment of the Safety of Seniors Act of 2007, submit to Congress a report describing the findings of the Secretary in conducting such review.''.

The SPEAKER pro tempore. Pursuant to the rule, the gentlewoman from California (Mrs. CAPPS) and the gentleman from Georgia (Mr. DEAL) each will control 20 minutes.

The Chair recognizes the gentlewoman from California.

GENERAL LEAVE

Mrs. CAPPS. Madam Speaker, I ask unanimous consent that all Members may have 5 legislative days to revise and extend their remarks and include extraneous material on the Senate bill under consideration.

The SPEAKER pro tempore. Is there objection to the request of the gentlewoman from California?

There was no objection.

Mrs. CAPPS. Madam Speaker, I yield myself such time as I may consume.

Madam Speaker, I rise in strong support of Senate bill 845, the Safety of Seniors Act.

Falls represent a serious health risk for millions of older Americans. In the United States, one of every three persons age 65 or older falls each year. Falls are the leading cause of injury deaths and the most common cause of injuries and hospital admissions for trauma in older adults.

Senate bill 845 seeks to address the growing problem of falling and fall-related injuries among older adults. This legislation would direct the Department of Health and Human Services to oversee and support national and local education campaigns focused on reducing falls and preventing repeated falls among older adults. It is important to note that the House Committee on Energy and Commerce held a markup of the House companion legislation H.R. 3701, the Keeping Seniors Safe From Falls Act, which was introduced by Health Subcommittee Chairman FRANK PALLONE. The committee amended H.R. 3701 to ensure that it was identical to Senate bill 845, which has already passed the Senate by unanimous consent. So I want to commend my good friend FRANK PALLONE for his hard work and commitment on this important piece of legislation.

I urge my colleagues to support Senate bill 845.

Madam Speaker, I reserve the balance of my time.

Mr. DEAL of Georgia. Madam Speaker, I yield myself such time as I may consume.

Madam Speaker, my wife and I had the opportunity to take care of my mother and her parents in their later years for a period of about 8½ years prior to their passage some 1½ years ago. We were always aware of the danger that was posed by falls, and certainly falls are one of the main causes of injuries and hospital admissions for senior adults.

S. 845, the Safety of Seniors Act of 2008, tries to address this danger by focusing attention on preventing falls among senior citizens and conducting research to evaluate the cause of falls among our older adults. The legislation provides the Secretary with discretion to implement a national education campaign, and, also, it gives him authority to evaluate the effectiveness of community programs designed to prevent falls. It also gives the Secretary the ability to create demonstration projects focused on evaluating and preventing falls in senior citizens.

I urge the adoption of this bill.

Madam Speaker, I yield back the balance of my time.

Mrs. CAPPS. Madam Speaker, I have no further requests for time, and I support the passage of Senate bill 845, which seeks to address the growing problem of falls and fall-related injuries among older adults.

Mr. PALLONE. Madam Speaker, many of us have elder parents, relatives, neighbors or colleagues who have experienced an unnecessary fall. Recently, Nancy Reagan and Senator ROBERT BYRD have both suffered from falls that have caused them to be hospitalized.

Falls among elderly Americans in fact are so commonplace that one in three Americans over the age of 65 each year experiences a debilitating fall. As a result, it is the leading cause of injury-related deaths for older Americans.

The Centers for Disease Control and Prevention, CDC, estimates that fall-related medical expenses cost Americans more than $20 billion annually. Projections are that those expenses will climb to more than $40 billion over the next 15 years, posing additional burdens on already strapped Medicare and Medicaid funding.

Effective demonstration tests and comprehensive public information and education campaigns can help reduce and mitigate these avoidable and frequently disabling injuries.

To that end, I introduced H.R. 3701, the "Keeping Seniors Safe from Falls Act of 2007" with my good friend Representative RALPH HALL, which is the House companion to S. 845, the bill we are debating today. If enacted, this legislation would launch a comprehensive preventive care program and educational campaign to reduce the number and severity of falls to the elderly.

In closing I want to acknowledge all the hard work that went into this bill, including the work of my colleagues both here in the House and the Senate, as well as the Falls Free Coalition working group, which has been advocating for this legislation for sometime.

Madam Speaker, falls among the elderly are clearly an issue that affect and potentially imperil us all. This legislation offers a national approach to reducing these tragic events I urge my colleagues on both sides of the aisle to support this important bill.

Mrs. CAPPS. Madam Speaker, I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentlewoman from California (Mrs. CAPPS) that the House suspend the rules and pass the Senate bill, S. 845.

The question was taken; and (two-thirds being in the affirmative) the rules were suspended and the Senate bill was passed.

A motion to reconsider was laid on the table.

FOOD ALLERGY AND ANAPHYLAXIS MANAGEMENT ACT OF 2008

Mrs. CAPPS. Madam Speaker, I move to suspend the rules and pass the bill (H.R. 2063) to direct the Secretary of Health and Human Services, in consultation with the Secretary of Education, to develop a voluntary policy for managing the risk of food allergy and anaphylaxis in schools, to establish school-based food allergy management grants, and for other purposes, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 2063

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Food Allergy and Anaphylaxis Management Act of 2008''.

SEC. 2. FINDINGS.

Congress finds as follows:

(1) Food allergy is an increasing food safety and public health concern in the United States, especially among students.

(2) Peanut allergy doubled among children from 1997 to 2002.

(3) In a 2004 survey of 400 elementary school nurses, 37 percent reported having at least 10 students with severe food allergies and 62 percent reported having at least 5.

(4) Forty-four percent of the elementary school nurses surveyed reported that the number of students in their school with food allergy had increased over the past 5 years, while only 2 percent reported a decrease.

(5) In a 2001 study of 32 fatal food-allergy induced anaphylactic reactions (the largest study of its kind to date), more than half (53 percent) of the individuals were aged 18 or younger.

(6) Eight foods account for 90 percent of all food-allergic reactions: milk, eggs, fish, shellfish, tree nuts, peanuts, wheat, and soy.

(7) Currently, there is no cure for food allergies; strict avoidance of the offending food is the only way to prevent a reaction.

(8) Anaphylaxis is a systemic allergic reaction that can kill within minutes.

(9) Food-allergic reactions are the leading cause of anaphylaxis outside the hospital setting, accounting for an estimated 30,000 emergency room visits, 2,000 hospitalizations, and 150 to 200 deaths each year in the United States.

(10) Fatalities from anaphylaxis are associated with a delay in the administration of epinephrine (adrenaline), or when epinephrine was not administered at all. In a study of 13 food allergy-induced anaphylactic reactions in school-age children (6 fatal and 7 near fatal), only 2 of the children who died received epinephrine within 1 hour of ingesting the allergen, and all but 1 of the children who survived received epinephrine within 30 minutes.

(11) The importance of managing life-threatening food allergies in the school setting has been recognized by the American Medical Association, the American Academy of Pediatrics, the American Academy of Allergy, Asthma and Immunology, the American College of Allergy, Asthma and Immunology, and the National Association of School Nurses.

(12) There are no Federal guidelines concerning the management of life-threatening food allergies in the school setting.

(13) Three-quarters of the elementary school nurses surveyed reported developing their own training guidelines.

(14) Relatively few schools actually employ a full-time school nurse. Many are forced to cover more than 1 school, and are often in charge of hundreds if not thousands of students.

(15) Parents of students with severe food allergies often face entirely different food allergy management approaches when their students change schools or school districts.

(16) In a study of food allergy reactions in schools and day-care settings, delays in treatment were attributed to a failure to follow emergency plans, calling parents instead of administering emergency medications, and an inability to administer epinephrine.

SEC. 3. DEFINITIONS.

In this Act:

(1) ESEA DEFINITIONS.—The terms ''local educational agency'', ''secondary school'', and ''elementary school'' have the meanings given the terms in section 9101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801).

(2) SCHOOL.—The term ''school'' includes public—

(A) kindergartens;

(B) elementary schools; and

(C) secondary schools.

(3) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services, in consultation with the Secretary of Education.

SEC. 4. ESTABLISHMENT OF VOLUNTARY FOOD ALLERGY AND ANAPHYLAXIS MANAGEMENT POLICY.

(a) ESTABLISHMENT.—Not later than 1 year after the date of enactment of this Act, the Secretary shall—

(1) develop a policy to be used on a voluntary basis to manage the risk of food allergy and anaphylaxis in schools; and

(2) make such policy available to local educational agencies and other interested individuals and entities, including licensed child care providers, preschool programs, and Head Start, to be implemented on a voluntary basis only.

(b) CONTENTS.—The voluntary policy developed by the Secretary under subsection (a) shall contain guidelines that address each of the following:

(1) Parental obligation to provide the school, prior to the start of every school year, with—

(A) documentation from the student's physician or nurse—

(i) supporting a diagnosis of food allergy and the risk of anaphylaxis;

(ii) identifying any food to which the student is allergic;

(iii) describing, if appropriate, any prior history of anaphylaxis;

(iv) listing any medication prescribed for the student for the treatment of anaphylaxis;

(v) detailing emergency treatment procedures in the event of a reaction;

(vi) listing the signs and symptoms of a reaction; and

(vii) assessing the student's readiness for self-administration of prescription medication; and

(B) a list of substitute meals that may be offered to the student by school food service personnel.

(2) The creation and maintenance of an individual health care plan tailored to the needs of each student with a documented risk for anaphylaxis, including any procedures for the self-administration of medication by such students in instances where—

(A) the students are capable of self-administering medication; and

(B) such administration is not prohibited by State law.

(3) Communication strategies between individual schools and local providers of emergency medical services, including appropriate instructions for emergency medical response.

(4) Strategies to reduce the risk of exposure to anaphylactic causative agents in classrooms and common school areas such as cafeterias.

(5) The dissemination of information on life-threatening food allergies to school staff, parents, and students, if appropriate by law.

(6) Food allergy management training of school personnel who regularly come into contact with students with life-threatening food allergies.

(7) The authorization and training of school personnel to administer epinephrine when the school nurse is not immediately available.

(8) The timely accessibility of epinephrine by school personnel when the nurse is not immediately available.

(9) Extracurricular programs such as non-academic outings and field trips, before- and after-school programs, and school-sponsored programs held on weekends that are addressed in the individual health care plan.

(10) The collection and publication of data for each administration of epinephrine to a student at risk for anaphylaxis.

(c) RELATION TO STATE LAW.—Nothing in this Act or the policy developed by the Secretary under subsection (a) shall be construed to preempt State law, including any State law regarding whether students at risk for anaphylaxis may self-administer medication.

SEC. 5. VOLUNTARY NATURE OF POLICY AND GUIDELINES.

The policy developed by the Secretary under section 4(a) and the food allergy management guidelines contained in such policy are voluntary. Nothing in this Act or the policy developed by the Secretary under section 4(a) shall be